The Fortnightly
REVIEW
of
THE CHICAGO DENTAL SOCIETY
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Presentation of Dental Services*

By A. J. Peetz, D.D.S., Madison, Wisconsin

1. A Workable, Comprehensive Yearly Preventive Service for all Patients.

2. Can financial fluctuations be curtailed in our offices during periods of depression?

When the "depression" of 1933 swept the country it not only found the business and commercial world unprepared but also affected the professional world to the extent that it found many members so unprepared that they were forced to apply for government relief or work on W.P.A. Since a shortage of dentists does exist and as dentistry is a necessity, can we avoid fluctuations in our offices which were so prevalent in the time of our last depression which started with the stock market crash in 1929? There is no doubt that 1948 was the last of the bonanza years. Not only dentists but all business men forty years old or older should not expect to see the like of that again.

It was about 1929 that I read an article in one of our dental journals by Dr. George Wood Clapp of New York, who made a study of the reasons why some dentists are successful and others are not, although practicing adjacent to one another in the same building. At that crucial financial period he made a survey of five thousand dentists and stated that even during normal times a certain group was unsuccessful while another group was able to retain their practice to the extent that they still were able to buy new equipment and maintain beautiful homes. After an intensive study of why these men were successful in spite of a depression he discovered that they were interested in preventive dentistry.

YEARLY PREVENTIVE PLAN

I felt that there must be some solution of the loss of patients at a time of reduced incomes. Therefore, after a great deal of deliberation and study, I worked out what I call a Yearly Preventive Plan. I have had this plan in operation for twenty-one years and it has proven to me that it is the most workable method that can assure the patient that he will minimize his dental troubles as well as the possibility of never having to wear dentures. The Preventive Plan is a yearly service which consists of complete mouth x-rays, a preventive treatment every four months (and we do not use the term "prophylaxis" or "cleaning"), a toothbrush demonstration and a continual supervision of same. This service is performed for a stipulated fee to be paid at the time the x-rays are taken.

The first few years I had the plan in operation it was optional whether the

* Read before the Midwinter Meeting of the Chicago Dental Society, February, 1949.

patient desired to go on this plan or not, but in the last ten years I have made it compulsory. If they do not subscribe to the plan I do not accept them into my practice. I feel that if a patient is not interested enough to invest a small amount of money for preventive dentistry then he is not a good patient and will eventually drift elsewhere. In the twenty-one years that I have had this plan in effect in my office I have proven two things. First, the patient who is on this plan has a beautifully clean mouth and, secondly, the immaculate care that is given minimizes the chance of loss of teeth. If a mouth is radiographed yearly and receives a minimum of three preventive treatments a year, as well as proper toothbrush supervision, there is very little chance of any oral breakdown, unless a patient has some serious systemic condition. My point in having them pay the fee for this plan in advance is that they will come in regularly when notified. If this phase is neglected and it is up to the patient to make an appointment every four months and pay for the treatment as it is given, few of them will report regularly. Also if they were to pay for x-rays individually and for the preventive treatments every four months the cost would be prohibitive to the average patient. By paying in advance for the plan he will keep his appointments and receive the benefit of that for which he has already paid. The reaction of the public to this program has been very favorable as expressed by two professors at the University of Wisconsin, who subscribed to this plan about eighteen years ago. In both cases their statement has been, "if every dentist in the United States would operate such a plan, your profession would never have to worry about panel or socialized dentistry." Before putting this plan into operation I consulted several of the outstanding dentists in the United States including the dentist who was at that time President of the American Dental Association and they informed me that if such a plan could be put into practice it would be a great contribution to dentistry.

FULL TIME HYGIENIST

The preventive plan is only practicable when you have a full time hygienist in the office. Since many states now license hygienists, to employ a girl for this work is not only effective, but highly profitable. It has been my experience not to permit the hygienist full responsibility as far as treatment and toothbrush technique is concerned. If a patient is on the plan for several years and is not following through with the instructions given him, he is again given an appointment with the dentist who will repeat the instructions with him as well as to inform him that it is his responsibility to carry on.

As dentists, our greatest trouble is that we are too anxious to begin work without having the proper understanding of the conditions that exist in the mouth. By conscientiously working such a plan you become more interested in the surrounding tissue and you have a better understanding of the patient's wants. Unless this preventive service, which is a well defined efficient plan, is functioning from the beginning to the end of each case, it will not be very successful. The second appointment is for the diagnosis of the x-rays and a complete survey of the mouth. A chart is made of the previous work which has been done, and other pertinent information as to the age of the patient, condition of the gums, condition of the teeth, abnormalities of occlusion, etc. It is very important at this time that we examine thoroughly the condition of the gums. It is hard to understand why so few members of our profession do not recognize tissues that show a marked deficiency. The companies who are in the commercial field advertise such slogans as "four out of five have it," etc., until the people are beginning to recognize that when gums are bleeding or inflamed they need attention. Yet, in many cases the patient will tell you that he has been to his dentist and all the information he was able to get was to brush harder, or he was getting older and would soon lose his teeth anyway. Nothing was done to instruct the patient as

to what could be done to improve this condition of which he himself was conscious. With such a circumstance it is not hard to understand why we are not held in esteem by the medical profession and the public as well, and are referred to as "tooth mechanics." This proves the point that members of our profession are too interested in the mechanical side of dentistry. We will lose a real opportunity if we do not devote some of our time to improving gum conditions as well as teaching the patients their obligations to their mouth condition. By putting in some form of preventive plan we definitely can recognize conditions of this type in their incipiency, and as soon as the dentist recognizes this condition and remedies it, he gains the confidence of his patient. I believe many of our patients leave our practice because of the laxity shown regarding proper tootbrush technique and the haphazard methods used when making a diagnosis. Since so many of our dentifrice companies are educating the public to the importance of seeing their dentist because of bleeding gums, we should cooperate to the point of at least recognizing and instructing them as to the dangers of this condition. Toothbrush technique is demonstrated with a large model and brush, as well as having the patient bring his toothbrush to give you the opportunity to see what type of toothbrush he uses and how he cares for the brush. You have probably noticed when traveling that in the Pullman washrooms you see people using filthy, worn-out toothbrushes although you know they have the means to have the best. The reason for this is that we have not assumed the responsibility of teaching them the care and proper use of a toothbrush.

RECOMMENDATIONS

After the patient is on the plan and has had his x-rays, pulp vitality test, study models and a preventive treatment, and after I have made my diagnosis, I give him another appointment for estimates and recommendations of the work to be done to restore his mouth to a healthy condition. Since some patients are not in a financial position to have me completely rebuild the mouth, I outline a program whereby I can do the most necessary work, be it either restorative or gum treatments. Then, I recommend that the other work be taken care of at a later time. On this third appointment, the patient is likely to be apprehensive and nervous as he expects the worst. It is well to take this into consideration and calm his fears right in the beginning. Never say "we have bad news for you." even if you have found that the only solution to his problem is to have all teeth extracted. Explain in this case he has a fine ridge to work on and that he is very fortunate because with modern dentistry, replacements can be made beautifully. It is advisable to show the patient the x-rays explaining in detail what is to be done and the condition of the mouth. At the time the appointment is made for the patient to receive your recommendations and estimates always impress them they are not investing in inlays, amalgams or synthetics, but they are investing in your time and skill. Never mention materials, since doing that creates shoppers. Many times we have patients ask us about vitallium or Chayes, etc. It would be a great deal better that we impress them as I said before, that the investment is in our skill and time.

The plan was described in one of the dental journals and from the number of letters received following this publication, I am convinced that many dentists are interested in instituting such a plan in their practice.

EDITORIAL

WHERE THE MONEY GOES

A veteran writing, as he explains, for himself and several of his confreres, wants to know for what purposes his dues money is spent. He acknowledges that the portion of his $37.00 that is retained by the Chicago Dental Society is spent to good advantage. (The breakdown on local society dues, as furnished by the Treasurer, was published on page 6 of the February 15 issue of this magazine.) But he is curious as to what the State Society and the A.D.A. do with their portions, $10.00 and $12.00, respectively.

It is a bit difficult for members of the Chicago Dental Society, whose Midwinter Meeting means so much to them, to realize that the State Meeting means just as much to downstaters. The State Meeting is somewhat of a tradition. The fact that it is small and compact gives just that much more opportunity to renew old acquaintances at a leisurely pace.

As explained by the Treasurer, the Chicago Dental Society can't begin to live on its dues alone and keep up its present activities. The Midwinter Meeting profit makes it up. And the reason the Midwinter Meeting makes a profit is because the crowd is big enough to make it worthwhile to the exhibitors who pay the freight. The State Meeting, on the other hand, doesn't pay its way, so it must depend on dues to some extent.

Then there are the various committee activities. The Public Policy Committee, the Committee on Dental Health Education, the Study Club Committee, the Relief Committee, the Public Welfare Committee and the Membership Committee, to mention a few, that do yeoman work and all this costs money. The Executive Council, on which Chicago has six representatives, is the watchdog of the State Society treasury. They see to it that the dues money is well spent.

The activities of the A.D.A. are too numerous to mention chronologically. One has but to read the *Journal* to realize that the organization is big business today. The Central Office, a building of which every member can be proud, represents a considerable investment. Salaries, committee and council activities, meetings of the Board of Trustees and House of Delegates all take money.

It is unfortunate that every member of the A.D.A. cannot at some time sit in the House of Delegates and watch the wheels go 'round. It's an education in itself. Just as the Executive Council is the watchdog of the State treasury so is the Board of Trustees, with representation from every section of the country, the watchdog of the A.D.A. treasury. But finally, and inevitably, the budget has to be approved by the House before final adoption. With nearly 400 delegates privileged to pick it apart, it really is scrutinized. There can be no waste of dues money with that kind of a set up.

OUT OF A HAT

Oscar Ewing, the Federal Security Administrator, in his recommendations concerning his national health insurance plan, suggests that the output of dental graduates should be increased so that by 1960 we will have 95,000 dentists. This, roughly, means an increase of 20,000.

In his own adroit way, Mr. Ewing neglects to give details as to how this feat can be accomplished. But assuming that it can be done, how can he, or anyone else, know that by increasing the number of dentists to 95,000 his program will be taken care of? Maybe that will be only enough to take care of the needs of the rising population under our present system of dental service.

Under a system of compulsory health insurance, if we can believe what we read about Britain's expensive experiment, there will be a tremendously increased demand for dental care. Mr. Ewing's figures may be correct, but it looks from here as if he just picked them out of a hat.

AUXILIARY PERSONNEL

Elsewhere in this issue is carried an article by Dr. A. J. Peetz of Madison, Wisconsin, relating to presentation of dental services. His plan, obviously, is intended to benefit the dentist but, by and large, should benefit the patient as well. It has received such favorable comment from laymen as this: "If every dentist in the United States would operate this plan, your profession would never need to worry about panel or socialized dentistry."

The employment of a hygienist is imperative in Dr. Peetz' plan and they, at last report, were hard to get. Here again existing programs of training must be expanded if we are to make good use of auxiliary personnel. If we can't train dentists fast enough, maybe we can train a sufficient number of hygienists in the next year or two to take up the slack.

JOURNAL OF ORAL SURGERY GROWS APACE

With the advent of the January, 1949, issue, the *Journal of Oral Surgery* joins the ever increasing ranks of magazines that are trying something new and different to catch reader interest. Its face change makes it more attractive and its type change makes it easy on the eyes. Along with the change in format there is also a change in editor. After six years of meritorious service, Dr. Carl W. Waldron has relinquished the reins and turned over his editorial stint to Dr. Reed O. Dingman. Dr. Waldron will continue to serve on the editorial board and continue to contribute timely articles to the *Journal*.

Dr. Dingman is well known in Chicago Dental Society circles. He has been a repeat performer on the Midwinter Meeting programs both as essayist and clinician. He is associate professor of oral surgery at the University of Michigan School of Dentistry, and is extremely well fitted by training and experience to take over the editorship of the *Journal*.

Because of his exceptional grasp of the general practitioner's problems, Dr. Dingman can be expected to make the *Journal* equally as valuable to them as to the oral surgeon. Under Dr. Waldron's guidance the trend was toward more articles dealing with major oral surgery. If the January issue is any criterion, under Dr. Dingman's guidance the trend now is toward more articles dealing with minor oral surgery. In any case, we can unhesitatingly recommend the magazine to our readers. We know of no other $5.00 investment that will give so much in return.

NEWS AND ANNOUNCEMENTS

A.D.A. SPEEDS UP PLANS

The Board of Trustees of the American Dental Association has voted additional appropriations to finance an expanded information program concerning national health planning. Through the agencies of the Bureau of Public Information, the Council on Legislation and the Council on Dental Health, information relating to compulsory health insurance will be distributed to both the membership and to the general public. The largest single item of the appropriations is earmarked for the preparation and distribution of special pamphlets and brochures suitable for distribution to the general public. The general membership, however, will receive within the next few months several bulletins which will contain information regarding all the health proposals now being advocated by Congress.

To better combat the issue of compulsory health insurance, the A.D.A. has registered under the federal lobbying act and Mr. Francis Garvey, secretary of the Council on Legislation, has been named the registered agent of the Association.

MICHIGAN STATE MEETING

The Michigan State Dental Society will hold its 92nd Annual Meeting in Detroit on April 11, 12 and 13. The three day program will consist of essays, limited attendance clinics and scientific motion pictures.

Among the essayists who will participate are Dr. Ernest Granger, "Hydrocolloid Procedures"; Dr. Floyd Ostrander, "Sulfonamides and Anti-Biotics"; Dr. Roy Ellis, "The Child Patient Today and Tomorrow"; Commander James Bradley, "Diagnosis and Treatment of Oral Neoplasms"; Dr. Merrill Swenson, "Full Dentures"; and Commander William Wohlfarth, "Acrylics."

On the lighter side, there will be a special showing on Monday evening, April 11, of colored movies of the 1948 Olympic Games and on Tuesday evening, April 12, the traditional "Night Club Frolic" will hold sway.

The convention will be housed in the Statler Hotel and accommodations are available at either that Hotel or at the nearby Tuller and Book-Cadillac Hotels.

Members of the Chicago Dental Society are cordially invited to attend any and all sessions.

CAPTAIN DAVIS PROMOTED

Captain Robert S. Davis has been promoted to the rank of rear admiral in the Navy Dental Corps. He will be remembered as one of the officers who went all out for administrative parity of the Navy medical and dental services.

CINCINNATI HOLDS CLINIC MEETING

The Cincinnati Dental Society will hold its March Clinic Meeting at the Netherland Plaza Hotel in Cincinnati on March 20, 21 and 22. Many outstanding essayists and clinicians will take part. Members of the Chicago Dental Society will be most welcome at the Meeting.

ENDODONTISTS ELECT

The American Association of Endodontists at its Annual Meeting in Chicago, preceding the Midwinter Meeting, elected new officers. The meeting was presided over by Dr. Louis I. Grossman of Philadelphia, who at the conclusion of the meeting turned the gavel over to the new President, Dr. E. A. Jasper of St. Louis. The newly elected officers of the Association are: President-Elect, Dr. R. L. Girardot of Detroit; Vice-President, Dr. S. C. Sharp of Pasadena; Secretary,

Dr. N. W. Burkman of Birmingham, Michigan; Treasurer, Dr. Vincent B. Milas of Chicago; Executive Committee, Dr. H. H. Pearson of Montreal; Dr. L. A. Lucas of Oklahoma City and B. L. Wolfsohm of San Francisco.

HANDBOOK ON CANCER

A new handbook for dentists on cancer has been prepared by the Tumor Committee of the Connecticut State Dental Society. The handbook contains a colored atlas section of seven plates reproduced from 42 kodachrome slides made available by the Yale University School of Medicine and the Grace-New Haven Community Hospital. The monograph has been prepared to alert the dental profession to its responsibility in detecting early malignant lesions as the dentist is in the best position to make an early diagnosis of lesions of the buccal cavity and adjacent organs.

Copies of the handbook may be obtained through the State Department of Public Health, Division of Public Health Dentistry, Springfield, Illinois.

DRIVE TO OBTAIN PHYSICIANS FOR ARMED FORCES RECOMMENDED

A nationwide drive for volunteers to relieve the critical shortage of physicians and dentists in the armed forces was recommended February 5 to Secretary of Defense James Forrestal. The project was proposed by the recently appointed Armed Forces Medical Advisory Committee. It would be directed mainly toward approximately 15,000 young men who were deferred from service in order to complete their professional training—many at government expense. The Committee recommended that an appeal be made for volunteers from among these men to avoid the necessity of asking Congress for additional legislation to meet critical needs of the armed forces. The program will be conducted by the Medical Advisory Committee with the cooperation of the medical and dental professions and the medical services of the Army, Navy and Air Force. It is estimated that by the end of July there will be a shortage of medical officers in the armed services of about 1,600 physicians and about 1,160 dentists and that by the end of the year the combined shortage will total approximately 2,200 physicians and 1,400 dentists. The medical profession should respond to this appeal with the spirit that has been traditional in American medicine. Thus the medical profession will show that it merits the freedom that it now seeks to maintain.

DENTAL RESERVE OFFICERS AND OFFICERS OF ALLIED CORPS TO HOLD DINNER-DANCE

Our annual spring dinner-dance and general get together will be held at the Congress Hotel, March 30. Each and every Reserve Officer of the Dental Corps, the Medical Corps, the Medical Service Corps, the Nurse Corps and other allied groups are invited and expected to attend with wives, sweethearts, or friends. Top echelon guests have been invited to bring us to date on subjects of vital interest and importance to all of us. An excellent dance band has been procured.

Fellow officers we must support this affair. In recognition of its importance to esprit of the units, attendance credit will be allowed. Uniform is preferred but civilian adornment is acceptable.

UNIVERSITY OF ILLINOIS FALL COURSES

The University of Illinois College of Dentistry is formulating plans for a course of six round table discussions and symposia on "Current Advances in Dentistry" to be given this Fall. These programs will be an innovation in postgraduate instruction inasmuch as they will be transmitted by telephone to dental

societies throughout the nation in cooperation with the American Telephone and Telegraph Company.

The University of Illinois has pioneered in the telephone transmission of postgraduate courses during the past two years. Lectures in "Caries Control" and "Oral Diagnosis and Cancer" were transmitted to groups of dentists in downstate Illinois, Pennsylvania and Louisiana. Because of its success in this field the University is expanding its activities. The two hour presentations are designed to serve as monthly programs for dental societies and are scheduled for October and November of this year and the first four months of 1950.

The faculty for the series will be assembled from all parts of the United States and will consist of dental specialists of wide reputation. The subject matter will include caries control, dentistry for children, dental education and public health dentistry. Dr. Saul Levy, a member of the faculty of the College of Dentistry, will serve as chairman of the program.

The series will be supervised by the College of Dentistry's Division of Postgraduate Studies, headed by Dr. Isaac Schour. Dental societies interested in participating in the program are urged to contact Dr. Allan G. Brodie, Dean, University of Illinois College of Dentistry, 1853 West Polk Street, Chicago 12, Illinois.

Minutes of the Regular Meeting of the Chicago Dental Society

North Ballroom—Stevens Hotel
January 18, 1949

The fourth regular meeting of the current series was called to order by President Wells at 8:20 p.m.

Dr. Wells reported to the membership that the minutes of the meeting of December 21 had not been published in THE FORTNIGHTLY REVIEW as yet and since they were rather lengthy he suggested that action upon them be postponed until the April meeting. It was then regularly moved and severally seconded that the approval of the minutes of the December 21 meeting be deferred until April. Motion carried.

Reports of boards and standing committees—none.

Reports of special committees—none.

Unfinished business—none.

New business—

Dr. Frank Wilkinson, Dean of the University of Manchester Dental School of England, who is visiting in the United States, was then introduced by President Wells. Dr. Wilkinson expressed a few words of greeting on behalf of the President of the British Dental Association and the Royal College of Surgeons of England, and expressed his appreciation of the many courtesies extended to him during his visit.

President Wells in reply asked him to convey the good wishes of the Chicago Dental Society to the British Dental Association.

Dr. Warren Willman, Chairman of the Monthly Program Committee, was then introduced. Dr. Willman in turn presented Dr. Emil D. W. Hauser who spoke on "The Orthopedist Looks at the Dentist."

At the conclusion of this discussion by Dr. Hauser, Dr. Willman on behalf of the membership of the Society thanked him for his interesting presentation.

There being no further business the meeting adjourned at 9:30 p.m.

Respectfully submitted,
Arno L. Brett, Secretary.

BOOK REVIEW

Practical Orthodontics: *by George M. Anderson, D.D.S., Professor of Orthodontics, Baltimore College of Dental Surgery, Dental School, University of Maryland; Seventh Edition, 541 pages, $10.00, C. V. Mosby Co., St. Louis.*

Isaac Abt once said that any scientific textbook was obsolete before it was off the press. Similar statements have been made by other writers; William Lyon Phelps for one, wrote at some length on the topic of the constancy of art and the instability of science. There are notable exceptions to this rule, such as Bowditch's *Practical Navigator,* Machiavelli's *The Prince, The Bible* and so on. The reason for this obsolescence, of course, is that in any science, and particularly in a science as young as orthodontics, during the years that are required for writing and publishing a textbook, scientific investigation may have established new facts which require changes in clinical procedure. If these changes are distinct enough, much of the book will be out of date. It is with this approach that the student or practitioner of orthodontics should read this book.

There are, however, several instances in which the orthodontist who reads it may experience some disappointment that the author has not included in this 1948 edition several principles and practices which are today, more or less, in general use.

The most striking examples of this are in the discussion of the differential diagnosis and analysis of the Class II case of malocclusion, treatment planning, the extraction of teeth in orthodontic treatment and in the discussion of orthodontic anchorage. In discussing Class II, Division I cases, although there is evidence that the author appreciates that these cases are not all alike, no definite plan is suggested for their differentiation. While there is a chapter by Broadbent on his original cephalometric growth studies, the reader does not find a discussion of the clinical application of cephalometrics to case analysis and treatment planning as used by Downs, Thompson, Wylie and many others. There is no comprehensive discussion of the growth of the mandible, its effect on the denture pattern, and the influence of mandibular rest position on case analysis and treatment planning.

In discussing the extraction of teeth, the words *mutilation* and *compromise* are still used in spite of the excellent results in denture and face that are being obtained throughout the country at this time by many clinicians who use this method quite generally, and without regard for the work of Kjellgren in the progressive extraction of teeth in non-orthodontic cases.

There is an elaborate classification, but no exhaustive discussion of the problems of orthodontic anchorage, and occipital anchorage is dismissed in one statement to the effect that this method is not often used, since it is "now displaced by simpler and less conspicuous sources of resistance to force." These statements may seem surprising to readers who are familiar with the works of Fisher, Kloehn and many others who show excellent clinical results in cases treated by this plan, and who regard intermaxillary anchorage as inadequate and even detrimental in some cases.

In his discussion of vertical dimension of the face the author includes the familiar statement that in the adult, "with the loss of teeth, the face begins to shorten again, with a closer approximation of the chin to the nose." He obviously refers to the occlusal vertical dimension, for he does not discuss rest vertical dimension, the constancy of which has been described by many investigators in the fields of orthodontics, full and partial denture prosthesis.

This book has considerable historical interest, and is a valuable reference book. It includes chapters by Weinberger,

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Operative Technic and Office Procedure for the Care of the Child Patient*

By Alfred E. Seyler, D.D.S., Detroit, Michigan

In early history one finds but very little record of efforts made to care for the medical and dental needs of children. I suppose that toothaches, and "gum boils" were accepted as a necessity in the natural course of growth and development, much the same as were the many diseases of childhood such as measles, whooping cough, and diphtheria. But a sense of responsibility and regard has gradually grown into our personal, professional viewpoint and into public thinking, until now the health and education of the children in our midst are accepted as a matter of personal and public obligation. We have collectively and individually encouraged the passage and support of the principles of child-labor laws, compulsory education, and immunization against contagious diseases. One need not look any further to find evidences of our regard for the children of our Nation.

But how about the dental care that is available to these same children? Have you and I accepted personally our obligation to provide the necessary dental services for children?

I would address particularly you listeners who are willing to accept your obligation as practitioners of general dentistry to care for the dental needs of the average child, but who may have been misled into believing that such care requires the knowledge and training of a specialist in dentistry for children. I know that there are such characters as—pedodontists—especially licensed to do dentistry for children—I happen to be one myself—but I know too that there are men who are licensed oral surgeons and exodontists to whom you could refer all your extractions if you wished. Some of you do refer all such work, but the average practicing dentist in the United States does his own uncomplicated extractions.

I feel you should follow that same concept in regard to the dentistry necessary for the average child—do it yourself—it's within your operative ability and it's your obligation—not the obligation of the children's clinics, public health bureaus, or possible Federal Bureaus. In the average dentistry required for children you're just as well qualified as a pedodontist.

ADULTS VS. CHILDREN

It seemed to me, as I prepared this paper last month, that I would be speaking to a group of average dentists—pretty well informed and capable in the matter of general operative dentistry, so this morning I shall merely try to emphasize some of the points of difference between accepted good practices in operative dentistry for adults and good operative dentistry for children. I will try to keep this practical.

First of all there is the matter of cavity depth. Silver amalgam restorations require a certain minimum bulk in order to stand up under masticating stresses, and ofttimes in a primary tooth which is not deeply carious, and where the pulp has not receded, it is necessary and indicated to obtain such bulk by widening the occlusal isthmus and dovetail of an MO, DO or MOD restoration beyond what is considered good cavity preparation in a permanent tooth. In preparing an MO on the lower 2nd primary molars remember that the mesiobuccal horn of this pulp is a very possible point of exposure, due to its being larger than the lingual horn, and on this tooth the width is obtained toward the lingual in preference to the buccal.

*Read before the Midwinter Meeting of the Chicago Dental Society, February, 1948.

On a first primary molar, either upper or lower, it is not necessary to extend the occlusal step past the central portion of the tooth but, rather, the preparation should terminate in the distal ⅔ of the tooth, not crossing the ridge into the mesioclusal pit.

PRIMARY CUSPIDS

Restorations on the distal surface of the primary cuspids are often prepared as typical class III proximal restorations and filled with silicate or the zinc-silicate type of material. These restorations often loosen, because adequate retention is unobtainable in the dentin of the tooth without too closely approaching the pulp or leaving a thin, weak wall. Our experience has been that it is wiser to make this preparation a modified lingual lock preparation, much the same as advocated by Cleveland's Carl Miller, for use on permanent cuspid teeth where silver amalgam is the restoration material of choice. Again the isthmus connecting the proximal portion and the lingual dovetail must be fairly wide. A restoration such as this must be placed with a matrix band, preferably the all-around or continuous type, and with proper manipulation of the amalgam will last as long as the tooth, which is usually lost about the eleventh year.

There is one phase of cavity preparation for a two surface restoration which is even more important in the primary teeth than in the permanent teeth. I refer to the bevelling of the pulpo-axial line angle, which, because of the necessary shallowness of the occlusal referred to previously, is absolutely essential for strength at this, the weakest point of most amalgam restorations. Remember to do this on the lingual lock cuspid preparation as well as on the conventional MO, DO and MOD preparations. It isn't necessary to use a chisel to place this bevel —a round or fissure bur can remove the dentin accurately and provide for the additional bulk desired.

UPPER INCISORS

The upper incisors of the primary dentition frequently present with carious proximal surfaces. Depending upon the depth of the caries, the age of the child and the degree of susceptibility to caries evident in the mouth, it is considered good dentistry for children merely to disc the proximal surfaces of the teeth involved and polish them well with sandpaper discs. We try to round off the sharp angles and edges thus formed and end up with a tooth that is approximately the same shape as before discing, except that it tapers from the incisal to the gingival and is smaller than originally.

If discing to a safe and sensible extent does not accomplish the removal of the carious structure, a preparation consisting merely of a round "hole" with adequate retention around the margin, may be made. We use silver amalgam or one of the zinc silicate cements as the filling material of choice.

Just so there may be no doubt in your minds as to the acceptability of this procedure, insofar as the maintenance of space for the permanent teeth is concerned, let me recall to you that the presence of the primary incisors in the upper jaw is not necessary for the creation or preservation of space for the permanent successors, since lateral expansion in this area is governed or produced by the growth of the bones of the face and head, independently of the teeth present. Opinions as to whether this is true in the lower incisor region seems to be divided. My personal opinion is that even in the lower anterior region the presence of the primary teeth is not necessary for the preservation of space for the permanent incisors.

In dentistry for children a modification of the typical Class I or simple occlusal amalgam preparation in the lower first permanent molar is often indicated. This modification is merely the limiting of the outline to a fissure following the natural fissures of the occlusal surface to this molar, which in 92% of all cases, accord-

ing to Hyatt, are either carious or precarious shortly after their eruption, which is the time to use this modified preparation. We suggest the use of a 556 crosscut fissure bur, and that the preparation be kept as near as possible to the width produced by that size bur as it included all the occlusal fissures of the tooth. The filling material of our choice is silver amalgam. We have just about completely discarded the prophylactic odontotomy technic which involved stoning out of the occlusal crevices or fissures of this tooth and the subsequent polishing and/or precipitation of silver nitrate in the suspected areas.

Of course, for all two surface restorations of amalgam, good dentistry dictates that a matrix band is necessary. I would no sooner tell you what kind of alloy to use than to tell you that there is only one type of matrix holder to use. We use several types of matrix retainers, depending on the circumstances at hand. And I'm sure that no matter whether you use a Wagner continuous band, a Siqveland, an Ivory or any one of the several other types of matrix holders, you use the kind you like best and with which you are most adept.

FRACTURED INCISORS

One of the most distressing phases of dentistry for children and young adults is the case of the fractured permanent incisor. Not only does the pleasing restoration of the fractured tooth become a matter of concern, but the maintenance of the vitality of the tooth ofttimes requires sharp judgment and prompt action by the operator. Of course, many of these accidents do not require any more attention than an initial radiograph to determine whether there has been a fracture of the root, plus follow-up radiographs at the regular prophylaxis check-up periods to be sure that no root-end pathosis has occurred. The tooth itself is disced down and polished so that its appearance is not objectionable and of course one can and should reduce the remaining incisors somewhat to render the fracture less obvious by comparison.

However, in the case of the tooth that presents with the pulp visibly exposed or with an extensive fracture that leaves a very, very evidently thin sheet or layer of dentin over the pulp—with the possibility that an undetectable exposure of the pulp has occurred, there seems to be at present, at least, only one procedure to follow and that is to do a vital pulpotomy on the tooth as soon as possible. Briefly the technic is as follows:

First of all, the fractured tooth, wherever possible, should be isolated by a rubber dam. The area, the instruments, the materials, should be surgically sterile. I have seen cases where the use of the rubber dam was impossible, and have used cotton rolls in such instances.

The tooth must be well anesthetized, the block or infiltration injections reinforced by the deposition of a drop or two of the anesthetic solution paradentally.

Using a large round bur, size 6, 7, or 8, the bulbous portion of the pulp is removed, to a level about 2 mm. beyond the crown portion of the tooth.

The debris is washed out with a 4-6% solution of sodium hypochlorite. Zonite is a readily obtainable and fairly stable solution for this purpose.

The hemorrhage is controlled by the use of Neo-synephrin 1% or Adrenalin Chloride 1:500, applied with a slight pressure on a cotton pellet.

Calcium hydroxide, (slaked lime) is mixed to a thick creamy paste with sterile distilled water or normal saline solution and laid over the pulp stump to the thickness of about 1-2 mm., this mixture is dried somewhat by tamping it to place gently with a cotton pellet, and a cement base is then placed in position, using a fairly good amount for thickness and strength.

That completes the pulpotomy procedure and a check radiograph should be taken at this time for a permanent record of the tooth.

FRACTURED POSTERIORS

Vital pulpotomy on a permanent posterior tooth is indicated when it is necessary to keep a tooth which has been exposed by caries or instrumentally in the process of a deep cavity preparation. The decision as to whether a vital pulpotomy, complete removal of the pulp or extraction of the tooth obviously depends on the individual case. The operator must consider the stage of development of the tooth and use radiographs to determine both that condition and the periapical appearance of the tooth. As a general rule, a tooth that is not completely formed, apically, is considered to be the best risk, since there would be a greater flow of blood into the tooth.

Time does not permit discussion here of the several restorations which have long been considered acceptable for the restoration and protection of a fractured anterior tooth. Each has its particular value and place in the hands of a conscientious operator. There is the simple orthodontic band, filled with cement, the full gold crown, the open face crown, the cast ¾ crown with a silicate window, the silicate with wire post or staple and the silicate with cast incisal edge and soldered or cast pin or staple. Esthetically speaking, these restorations usually leave much to be desired and since many of us who do dentistry for children are supposed to be able to accomplish the unheard of and frequently impossible, the parent is not completely appreciative of our efforts.

ACRYLIC JACKETS

We believe, in our office, that the most esthetic and practical restoration for a fractured incisor is an acrylic jacket, prepared without a shoulder. The tooth is disced on the mesial and distal surfaces, enough to permit a thickness of about 1-1½ mm. of acrylic, on the labial and lingual only enough of the enamel is removed to permit the acrylic crown to fit close to the tooth at the gingival and so that the finished tooth with crown cemented is not too much beyond the labial and lingual surfaces of the unharmed teeth. Naturally the tooth may appear slightly bulkier on the labial, but when the acrylic is correctly dentoured, that is, kept very thin on the labial, this will not be at all objectionable. Where a pulpotomy has been done on the tooth to be jacketed, a post or wedge of acrylic can be extended into the pulp chamber area, for increased retention. Shade is taken with the New Hue shade guide, and the same impression and bite procedure is followed as for a usual jacket crown.

Parents must be made aware of the limitations of an acrylic crown such as this, as far as permanence—or lack of it perhaps—and the likelihood that the child may dislodge or fracture it in the event of a blow or by the injudicious use of bubble gum.

The operative dentistry necessary to render a good service to children surely does not vary so much from that necessary to render good service to the adult patient. Although there is a need for well trained specialists in Pedodontics, the fact remains that the greatest service to the children of this country will come from conscientious men in general dentistry who realize their obligation to the parents of this country and are willing to provide good dentistry for the children, to the end that the dental problems of adulthood may become increasingly simpler and financially easier for everyone.

CHILD MANAGEMENT

I sometimes wonder whether we who do dentistry for children, either as a specialty or as a part of a general practice, are quite right in discussing the topic of child management. As I have watched senior students progress thru our Children's Clinic, I have seen mere instances when the behavior of the *operator* was open to question rather than the behavior of the child. And I'm sure that a similar situation exists out in practice when there is a question about management of the child patient.

And so, as I speak to you this morning, I would prefer to think that what I say will help you manage *yourself*, as well as your child patients, rather than to tell you what to do with the infrequent but *much* publicized behavior problem in the child patient. For that matter, *I* find fewer *true* management problems among my child patients than among my adults —(especially the denture patients!)

Last July I attended a Pedodontic Teaching Conference at Northwestern University, directed by Dr. George Teuscher and participated in by members of the School of Education of that University. Much of my material is from my notes of those lectures, and as such is fairly acceptable to the present day teachers of child psychology and students of child behavior. Observations I have made or procedures I follow in my own office also serve as a basis for my remarks this morning.

First—what is the origin of the child's emotional reaction to us—as dentists? Hagman says that a child's fears are 40% inherited from parental fears, and I suppose one could safely say that the balance of the child's fears are induced fears or fears acquired from environment. How shall we treat or overcome these three types of fears?

The best way to overcome the first 40% would be to re-educate the parents —but since such a procedure is highly impractical, if not impossible, I find it most practical to exclude parents from the operating room. It is much easier to establish a policy of "Parents out of the operating room" and make exceptions to the rule, than it is to request a parent to leave the room when a child misbehaves. For the life of me, I can't see why some men persist in working on a child in the presence of a doting parent who is continually trying to bolster up the child's morale for even such a simple operation as a prophylaxis. Encouragement, when encouragement isn't necessary, makes for fear. Let me repeat that —encouragement, when encouragement isn't necessary, *makes* for fear.

Please don't misunderstand me or my thoughts about commending or praising the child for his cooperation and his good behavior. Praise is one of the things that children—even as you and I—thrive on, and I use plenty of it as I work on my patients. But don't confuse unnecessary encouragement with deserving praise for good effort.

The second type of fear, induced fear, usually acquired when a child has been hurt in a dental office, and the third type of fear acquired from environment, are best treated by "reconditioning" the child to overcome his fear, either by the dentist or by the example of other children, as in a large clinic room.

TREATING FEAR

Poor useless ways of treating fear in a child are:

1. The old comment—"He'll outgrow it—let him alone until he's older."—99 chances out of 100 are that the fear will intensify, not decrease.

2. Verbal appeal to the child—such as "Be a big man"—"Act like a soldier," etc. You may succeed in making the child suppress his fears momentarily, but you can't succeed in eliminating his fear and apprehension permanently—and the next time the same procedure will be in order.

3. The idea of distraction—when the mother or dentist or the assistant says "Oh, look at the pretty picture on the wall, Jerry"—or, "Remember we're going to the dime store when we leave the doctor's office, dear." One of my friends tells about the child who used the drink method of distraction—that is taking a long, slow drink of water every time the going got a little rough, while the fond mother beamed at the youngster's ingenuity—that is she beamed until the doctor remarked that that was pretty expensive water—each drink costing about 20¢, since he was charging a fee for his time, not for his operative accomplishment!

One of the most debatable—and debated points of child management is the repressive—or strong arm—the so-called "Towel method" of control. Child psychologists who address groups of dentists

on child behavior condemn those of us who physically subdue a completely unwilling patient, but I believe that as a rule they are speaking of the child 7, 8, or 9 years of age—not of a child 3, 4, or 5 of pre-school age, before he has attended kindergarten. And from time to time we meet many silly sentimentalists who feel that a child should live in an earthly paradise and should never be subjected to pain or punishment!

I maintain that a child must be made aware of *some* of the necessities of life if he is to be a good member of society as we understand that implication today. It doesn't do a bit of good to ask a screaming child, "What are you crying about?"—or—"Why are you such a bad boy?" The child doesn't know—and probably doesn't care—so why ask him? A child who has never been taught at home the limits within which he must conform—and is "strong-armed" or physically subdued, and then becomes a good patient, usually appreciates the fact that he has met someone with a superior will, and accepts the fact. And that is exactly what I tell the parents of a child on whom I have found it necessary to use such a procedure. When I go to the waiting room or business office door with the child, I invariably advise the parent, "Don't ask Mary about today, and for goodness sake don't punish or scold her. We understand each other now, and she'll probably be one of my best patients from now on."

When you find it necessary to use the physical method of inducing behavior of the child, try to be fair about the situation. That is—when the child is willing to cooperate, forget the method used to obtain that cooperation, and concentrate on making it voluntary in the future. For altho you may easily control the acts of the child, because you're bigger and stronger than he is, you cannot control his *thinking* unless he is agreeable and willing. You must remember that each child is a unique and individual being, continually engaged in adjusting himself to the desires of adults, and once you have him adjusted to your desires—don't continue to beat him down. The sense of fair play and sportsmanship can well be carried into the dental office. When your opponent has lost a match of golf or tennis or boxing you don't ride him about his loss and make him feel inferior—nor should you continue to "bear down" on a subdued child.

LIKING CHILDREN

I believe that getting along with your child patients involves genuine liking for the small fry—not just a regard for them as a means of increasing your income or obtaining their parents as patients. You must remember that a child's behavior is usually somewhat of a reflection of your own behavior. If your approach to him is timid and uncertain, it is entirely likely he'll respond in the same manner. Or if you're hurried and impatient, the child will sense it, and his resentment won't add to your peace of mind or efficiency. Your own behavior will tend to condition the child's conception of you—and dentistry. If you're pleasant, self-controlled, and always master of the situation, the child will learn to respect and expect those traits in his dentist. Observe yourself critically—outside your office. See whether children stay shy and distant of you when you're introduced as a dentist—or whether they lose their wariness and accept you as a friendly sort of a fellow after a short time in your company. You may be sure that if you can't make friends with a child outside your office, you're never going to get to first base with him inside your operating room!

CHILDREN'S OPINION OF DENTIST

During this Conference at Northwestern which I mentioned a bit ago, Dr. E. J. McSwain of the School of Education presented a list of what children like about us dentists and also what they dislike. These lists are based on the answers of school children from 6-12 years of age in public schools, written in response to the teachers' request for the

(Continued on page 26)

NEWS OF THE BRANCHES

WEST SUBURBAN

From the looks of things, everything is quiet on the West Suburban front. . . . Barney Siegrist, our president, tells me that he hasn't any specific news at this time except the fact that his Mexican vacation is pretty nearly here. . . . Robert Sirimarco and Irv Clendenen have been recent victims of the flu bug. Hope both of you are feeling well again, fellows. . . . I just called Al Ryan, who tells me that he had been in the hospital for a minor operation. Al seems to be getting along fine now and is taking things easy until he gets stronger. . . . I am sorry that I haven't more news for this column, fellows, but . . . no tickee, no laundee. This is your column, gang. Let's do something about it.—*E. G. Walters, Branch Correspondent.*

WEST SIDE

At this time every year, the big topic of discussion among the West Side members is the coming election. From all indications, it promises to be a very hot and interesting election. Let the best men be elected. Regardless of who is elected, we will all get back of the newly elected officers in a forward movement for good and better dentistry. Our president, Sam Kleiman, has been selected as a candidate for the office of Vice President of the Chicago Dental Society. If elected, he will be a credit to the office. . . . Leo Cahill is away in Arizona for the purpose of some preliminary golf practice prior to trying to take John Reilly to camp. Leo always, it seems, experiences a little difficulty in winning a few quarter bets. He is usually on the short end. . . . William Walden is now somewhere South breaking in a new Cadillac. The Cadillac bug has bitten Vincent Vivirito because he too expects to be out on a tour breaking in a new one. . . . Frank Conklin will return next Sunday after having spent a month in Florida. . . . Jesse Owen is now on a six week vacation in and around Hollywood, Florida. . . . Everything has its price. George Blaha, Herman Nedved and Chester Bellan are all getting an increase in rent now that their building has been remodeled. . . . Frank Kropik recently took a course in children's dentistry in Minneapolis. He experienced some subzero weather while there. . . . If any of you fellows feel the urge to do a good deed, please visit Ernest Brogmus. He is so lonely since his wife went away on a vacation that he just can't eat. That must be love. . . . Bob Tuck has fully recovered from that attack of flu. . . . Harold Epstein wishes to announce that the last two meetings of the Forum will be held April 5 and 19. . . . Bill Ashworth is well out of the woods now and is recovering from his recent illness. We are glad to hear that you are back on your feet, Bill.—*Irvin C. Miller, Branch Correspondent.*

ENGLEWOOD

Paul Kanchier, Chairman of the Heart Fund drive, reports interest is high but contributions are low. When we consider the great incidence of cardiac disorders among professional men, this is a charity that should appeal to us. It could be that too many of us think of contributions in terms of dollars and tend to put off giving. A single dollar from everyone would produce quite a sizeable sum. . . . A quick glance at some of our more affluent brethren might be in order. . . . Ralph Rudder chased an elusive root tip to Arizona. . . . Zeke Krol figures a month of Florida's sun will give him the necessary strength to hoist out the deeply embedded third molars. I guess the answer is to become an oral surgeon and your worries will be over. . . . L. G. Blanchette also decided that a month in the Southland would be better for the nerves than the same time on our South Side. . . .

Ray Anderson said three weeks of Florida was just what he needed. . . . Frank Kuchler leaves for Natchez and New Orleans the last week of March. . . . A plug for the Committee on Dental Health Education. It's an activity that helps the profession discharge some of its public responsibilities to the community and in the long run brings many new patients into the dental office. A heavy program is outlined for Englewood during the next few months, so if you receive a call to donate a few hours of your time some Wednesday morning for a school examination, please don't refuse. . . . A glance at some of our less fortunate members. Bill Benson is at the Mayo Clinic, Colonial Hospital, for diagnosis and possible treatment. . . . R. J. Waska is still away from his office. The gang from his building, the druggist and salesmen got together and presented him with a special radio so that he could stay home a little longer. He can walk some now, so it might not be too long before he is back and plugging away. . . . After many years around Fifty-first and Halsted, Irv Oaf has moved to the sparsely settled district of Seventy-ninth and Halsted. Being right above a bakery, he probably thinks the carbohydrates below will produce more cavities in the teeth of his patients. . . . Hap Link, after a period of running offices at Eighty-seventh and Ashland and at Gurnee, Illinois, has made the complete break and is now a full time country practitioner. We should get lots of farm and livestock lore from him at the next Midwinter Meeting. . . . The April meeting is the annual election of officers. It's a democratic organization, so be there to exercise your franchise. If you don't like your present officers, don't re-elect them. After a year of hard work, that is what they are hoping for anyhow. . . . Please send any news items to our next correspondent, C. E. Bromboz, 3100 South Halsted Street or telephone him at VIctory 2-2353.—*Francis O'Grady, Assistant Branch Correspondent.*

NORTH SIDE

Time has come for another substitute writer to take over, so here it is. . . . Mrs. John A. Anderson proudly presented to her husband a 10 pound 5 ounce baby boy (Junior) on February 20. Not to be outdone by that, John carries it further by insisting that the new baby ride in a new buggy so by the time you read this he will be sporting his new Oldsmobile. Some fellows have all the luck. . . . Manley Elliott, Walter Nock, Ed Benson, and yours truly were present at the dinner given in honor of Dr. John Warnock and saw Carl Gieler present him with a book of fine letters from men of the profession. Carl Gieler, as you know, is president of the Sanders Study Club. . . . Marshall Nielsen and his family are in Florida having a grand time for a three week vacation. . . . Milburn Johnson has moved into his bungalow office at 2525 Peterson Avenue. His place is really grand and certainly a tribute to hard work well done. Best to you, Milburn, in your new location. . . . Many of our members are going to the Kenwood-Hyde Park Dental Society on behalf of the Cooley Study Club to present their next program of the month. . . . Russell Boothe has been elected president of the Society of Oral Surgeons. Nice going, Russ; you're the man for the job. Russ is also head of the North Side section in the Heart Association Drive for this year and wishes to urge all of you fellows that are going to donate to do so through your dental society if possible. . . . Clarence Peterson as usual was the spark plug of his class at the Chicago meeting and had a grand meeting room for the boys that attended. Mark Williams also was prominent there. . . . Our next program is to be a honey. On April 6, the North Side Branch will meet at the Edgewater Beach Hotel at 3:00 p.m. Dr. Henry Glupker will speak on "Rehabilitation of Edentulous Patients," and will show a colored motion picture. Dr. B. Placek will present a new approach to the inlay technic. Dinner will then be served in the usual fashion. Following dinner, Dr. Harold Hillenbrand, General Secretary of the American Dental Association, will discuss new legislation and dentistry.—*Herbert Gustavson, Ass't. Branch Correspondent.*

KENWOOD-HYDE PARK

The April meeting will be held Tuesday, April 5 at the Sherry Hotel and Dr. George Teuscher of Northwestern University School of Dentistry will present a paper on "Children's Dentistry." Dr. Teuscher is head of the Children's Dentistry department at the university and is an essayist of national repute. His sensible and practical approach to the care of children is always refreshing and helpful. There also will be an excellent array of clinicians on this subject. . . . Wayne Fisher reports that the May meeting will be devoted to socialized medicine and dentistry and what the A.D.A. is doing about it. At the present time it is the plan to have Dr. Harold Hillenbrand, Secretary of the A.D.A., as the principal speaker. This is a problem which should be uppermost in our thinking and needs the attention of each one of us. So mark off the date now. May 3. Plan to bring your lady. . . . My news hawks are becoming less and less hawks and more and more sitting ducks. You just can't blast any news out of them. However, thanks to Roy Eberle who sent me a card from Miami, we can give you a little news. Roy says that the weather is just too hot for peppy people, but that he is having a grand time and getting a good tan. . . . Louie Pendergast has moved his office in the Kenwood Bank Bldg. and is now all set in his newly renovated quarters. Don't work too hard, Louie. . . . The party for Harry Hartley was very successful and attended by 110 of Harry's friends who came to honor him for his faithful service to dentistry. Kenwood was very well represented and our president, Robert Wells, was one of the speakers. This was in no way a swan song for Harry, but rather an attempt to say thanks for a job well done. It is our sincere wish that you have many more years of devoted service and happiness, Harry. . . . The nomination committee composed of Willard Johnson, Bob Pinkerton, Wilbur Spencer, Harry Hartley, Elmer Ebert, Chairman, has the following slate to offer: President-Elect, Robert L. Kreiner; Vice-President, Wayne L. Fisher; Secretary, John J. McBride; Treasurer, J. R. Carlton. Larry Johnson will be installed as President at our May meeting. Election of officers will be held April 5. For dinner reservations call Stan Wrobel, PLaza 2-6020. Any news call me at SOuth Chicago 8-1823.—*Elmer Ebert, Branch Correspondent.*

WE ARE SURE YOU WILL NOT WANT TO MISS FUTURE ISSUES OF THE FORTNIGHTLY REVIEW

Coming issues will contain many important articles on current legislation pending in Congress, as well as many timely scientific articles.

If your 1949 membership dues have not yet been paid, send your check to the Central Office NOW so that your name may be kept on the mailing list.

Wanted: An associate in ethical, South Side, fully equipped modern office. Quality dentistry with competent staff, including hygienist. Permanent arrangement for man interested in good dentistry. Address B-10, The Fortnightly Review of the Chicago Dental Society.

Wanted: To purchase Loop dental office and good will. Cash transaction. Address B-4, The Fortnightly Review of the Chicago Dental Society.

Wanted: Experienced dental assistant or intelligent beginner wanted to work on Monday, Tuesday and Thursday. Telephone RAndolph 6-9498.

Wanted: An associate. A young conscientious dentist to share with me my well established general practice with privilege of full purchase in two years. Strictly modern two chair office, fully equipped with new and the finest of equipment. In reply, give age, education, experience, hobbies. Address B-12, The Fortnightly Review of the Chicago Dental Society.

Wanted: Competent, reliable associate to take over in near future a very successful and highly lucrative practice. Ideal for veteran or other dentist seeking new location on Southwest side. Choice, modern and up-to-date in every respect. Leaving state, but will stay until associate has become fully familiar with patients and routine. Address B-13, The Fortnightly Review of the Chicago Dental Society.

MISCELLANEOUS

Anesthetic Service: Nitrous Oxide-Oxygen administered by appointment in your office. Machine and gas furnished if necessary. Telephone Julia Baines, R.N., ANdover 3-3390 or Des Plaines 1096.

BOOK REVIEW

(Continued from page 13)

Broadbent, Rogers, Swinehart, Wright and Kitlowski. The general content is written in an informal, conversational style. It is in no sense a manual or handbook. Much valuable fundamental material is included, but as is the case in many other fields, the clinician must depend upon critical reading of the periodical literature in this field if he wishes to keep himself up to date on what goes on around him. In spite of the criticisms of this reviewer, who realizes that it is very much easier to review a book than to write one, this book is one of the five or six standard texts in the field of orthodontics. It should be included in every orthodontist's library.—*Waldo O. Urban.*

(Continued from page 19)

children's opinion of their own dentist. Obviously, there is quite a span of reaction periods from 6-12, but some of the answers will surprise and perhaps chagrin you.

Here are some of the things the children liked:

1. They liked the comic books in the waiting room which they could read while they waited.

2. They liked their dentist because he told them stories while he worked on their teeth. (Obviously this answer was mostly from the younger children.)

3. They liked their dentist because he was kind and understanding. He knew when the drilling hurt and would be careful not to make it hurt worse.

4. They liked their dentist because he always gave them a gift or souvenir.

5. They liked their dentist because both he and his office were so neat and clean.

6. They liked their dentist because the air and water made their mouths feel so clean.

7. They liked the buzzing of the instruments.

8. (And I suppose this answer came from the older children)—they liked their dentist because he had such a pretty assistant.

9. They liked their dentist because he gave them a mirror so they could watch him work on their teeth.

And here is a list of things they *didn't* like about their dentist:

1. They didn't like the pain of the drills and some of the instruments their dentist used.

2. They didn't like their dentist because he wasn't clean. His breath smelled bad, his fingernails were dirty, and he had B.O.

3. Their dentist was untruthful—"he says things won't hurt and they do."

4. They didn't like their dentist because "he treats me like a baby"—(He talked baby talk.)

5. They didn't like their dentist's waiting room—all the chairs were big chairs, and all the magazines were for grown-ups.

6. They didn't like their dentist because he "Keeps me waiting so long." (I know that I myself have made this mistake of sometimes keeping a youngster waiting while I took care of one or two so-called emergencies before the child, who had arrived on time for his appointment.)

7. "He asks me questions when I can't answer him—because he has my mouth

stuffed with cotton rolls or instruments." (I'll bet this is a universal fault among us—whether we're working on adults, or children!)

8. They didn't like the way the dentist's office smelled. The medicine odor was not nice. . . . In my office the assistant puts a few drops of oil of sassafras on the paper liner in the cotton roll drawer. Many children don't like cotton rolls—but when they have a nice odor, it seems they're not nearly so objectionable.

9. They didn't like their dentist because he "makes me come on Saturday!" —There's another argument for the committee of your local dental society to use in their effort to have children excused from school for necessary dental work.

There you have a few of the reasons why children like or dislike us as dentists, and in their refreshing outspokenness and candor, they may touch some of our sensitive spots.

As you work with children, remember that "Life consists of pain as well as pleasure. Desirable actions in children should be recognized and rewarded by praise, thereby encouraging them to repeat such behavior, and thus training them to do what we desire."

Try to make your dental care for children a two-way proposition. We want the child to work *with* us—to his own advantage, and if we can succeed in getting down to the child's level with dignity—using terms he understands—explaining the instruments when necessary and practical—and *listening* to *him* occasionally, I believe we'll all find it easier to do more and better dentistry for children.